



PURE COMPLEXIONS

Holistic Healing Consulting

7174 Pintail Dr, Carlsbad, CA 92011
Phone: 866-799-7276 Fax: 1-866-843-7977
Email: consulting@purebodysolutions.com
Website: www.purebodysolutions.com

Dear Patient,

Welcome! And thank you for choosing Amber Conway BSN RN as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:

During your initial New Client Consultation Amber Conway will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2:

Once you have completed your lab tests, Amber will explain the meaning of your test results to you in a follow up 30 minute consultation. She will create an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

STEP 3:

Subsequent consults are scheduled to monitor your progress.

We invite you to contact us via email or phone should you have any questions during the course of your treatment.

We may be reached at:

Phone: 866-799-7276

Email: consulting@purebodysolutions.com

Consulting Office hours are M-F 9:00am - 3:30pm PST. We also have morning and evening appointment slots available if needed.

We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

In health,

Amber Conway BSN RN and Staff



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New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Amber Conway to release my personal medical information to me.

Patient's Signature: _____

Date: _____

Name:			Date:		
Address:				Country:	
City:		State:		Zip/Postal Code:	
Home Phone:		Work Phone:		Fax:	
E-mail:			Cell Phone:		
Please mark your preference for occasional follow up communication from our office: ___ Email ___ Phone					
Age:	Birth date:		Sex: M F	Status: M S W D	No. Children:
Occupation:			Employer:		Years Employed:
Spouse's Name:			Occupation:		Employer:
Person responsible for this account:				Referred by:	
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					



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Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ Height _____ Blood Pressure (if known) _____ % Body Fat (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____
please list (attach sheet if necessary)

2. In the past, have you used birth control pills and/or antibiotics? _____

a. For how long? _____

3. If you have dental fillings, please list material(s) used: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin - Acne
Arthritis	Heartburn	Skin - Acne, Cystic
Asthma	High blood pressure	Skin - Acne, Premenstrual
Chest pains	High cholesterol	Skin - Dandruff
Chronic cold/flu symptoms	Hypoglycemia	Skin - Eczema
Chronic fatigue	Kidney problems	Skin - Rosacea (facial flushing)
Depression	Liver problems	Skin condition - Other
Diabetes	Osteoporosis	Thyroid condition
		Unexplained weight change

5. How much sleep do you get each night on average? _____



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6. Do you have any food allergies, sensitivities or restrictions? _____

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often? _____

b. How often, do you drink caffeinated beverages (tea, coffee, soda, energy drinks)? _____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.): _____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

a. Do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

12. What methods have you tried to lose/gain weight? _____



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13. How is your energy level?

a. Are there times in the day that you feel best? _____ worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress? _____

16. How do you deal with your stress? _____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes _____ No _____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes _____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes _____ No _____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes _____ No _____

e. Now and then I think I am a secret eater. Yes _____ No _____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes _____ No _____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes _____ No _____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No _____

i. I feel shaky if I don't eat on time or if I don't snack. Yes _____ No _____

j. I often find myself irritable or angry. Yes _____ No _____



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18. Check off any of the following that have applied to you within the last 30 days:

<input type="checkbox"/> Do you feel nauseous?	<input type="checkbox"/> Do you have abdominal/intestinal pain?
<input type="checkbox"/> Do you have bloating?	<input type="checkbox"/> Do you get bloated after meals?
<input type="checkbox"/> Do you get heartburn?	<input type="checkbox"/> Do you have diarrhea?
<input type="checkbox"/> Do you have constipation?	<input type="checkbox"/> Do you travel outside of the U.S.?
<input type="checkbox"/> Do you have gas?	<input type="checkbox"/> Are your stools compact/hard to pass?
<input type="checkbox"/> Do you belch following meals?	<input type="checkbox"/> Do you have gurgles in your stomach?
<input type="checkbox"/> Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit _____ Below average _____ Average _____ Above average _____ Very fit _____

25. How often do you exercise?

a. What is your exercise regimen?

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

27. What are your fitness goals? (circle all that apply)

<input type="checkbox"/> General fitness endurance _____	<input type="checkbox"/> Muscle toning
<input type="checkbox"/> Weight loss/maintain weight	<input type="checkbox"/> Muscle strengthening



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_____ Osteoporosis prevention	_____ Muscular coordination/balance
_____ Specific sport enhancement	Other _____
_____ Flexibility	

28. Surgeries, starting with most recent: _____

29. Hospitalizations: _____

30. Briefly describe where you have lived since childhood (please include all foreign countries): _____

31. What is your heritage? (Irish, Scottish, German, Spanish, etc.)

32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	Do you often:
Now Past Satisfactory	Now Past Feel depressed
Now Past Boring	Now Past Have anxiety
Now Past Demanding	Do you often:
Now Past Unsatisfactory	Now Past Have irrational fears
Do you worry over:	Now Past Feel upset
Now Past Home life	Now Past Feel things go wrong
Now Past Marriage	Now Past Feel shy
Now Past Children	Now Past Cry
Now Past Job	Now Past Feel inferior
Now Past Income	Have you:
Now Past Money problems	Now Past Seriously considered suicide
	Now Past Attempted suicide



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POLICIES AND PROCEDURES

New Patients

First Appointment: New Client Consultation

Your first consultation will be 45 minutes – 1 hour **\$125**. During this time Amber Conway BSN RN will determine the appropriate lab tests you should order to address your specific health concerns.

Fee Schedule

New Client Consultation: **\$125** (45 minutes - 1 hour)

Follow-up consultations:

- 1 hour: **\$80**
- 45 minutes: **\$60**
- 30 minutes: **\$40**
- 15 minutes: **\$20**

- ☞ Payment is due at time of consultation
- ☞ Methods of payment are: Check or money order (in advance), Visa, MasterCard, Discover, and American Express. We also accept all PayPal payment methods.
- ☞ Financing Option: We accept **PayPal Credit** Payments (formerly called Bill Me Later), which is 6 months No Interest Financing for orders > \$99. To use *PayPal Credit*, click *Pay with PayPal* and choose *PayPal Credit* during checkout.
- ☞ All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments

- ☞ Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.
- ☞ We encourage you to book your appointments 2 weeks in advance.
- ☞ As a courtesy to you, our office will email you to confirm your appointment one day in advance.

Lab Tests

- ☞ The results of your lab test(s) will be sent to our office 2 to 4 weeks after mailing your specimens to the lab.
- ☞ Amber Conway will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.



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Cancellations

- ☞ If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Returned Products

- ☞ PRE-APPROVAL is REQUIRED on ALL RETURNS!!
- ☞ We accept returns on unopened products up to 60 days after purchase date.
- ☞ Special order items CANNOT be returned!
- ☞ Refrigerated items CANNOT be returned!
- ☞ Prepaid tests can be returned for credit within one year of purchase.

Informed Consent

- ☞ I acknowledge that Amber Conway BSN RN and her staff members are not medical doctors. I understand that Mrs. Conway and her staff members provide nutritional and other health related information to help me attain and maintain my best health. All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health habits and nutrition. I understand that Mrs. Conway and her staff members do NOT diagnose, treat, cure or claim to cure cancer or any other disease.

Important Notes

- ☞ Amber Conway BSN RN does not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911!
- ☞ Please contact the office if you are not clear on any of our policies or procedures.

I _____ have read and understood
Pure Complexions Informed Consent, Policies and Procedures.
(please print name)

Date _____

Signature _____



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Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: Pure Complexions Holistic Healing Consulting - Amber Conway BSN RN

Address: 7174 Pintail Dr, Carlsbad, CA 92011

I, _____ request the following information:

- | | | | |
|---------------------------------------|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Test results | <input type="checkbox"/> History | <input type="checkbox"/> Records | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Reports | <input type="checkbox"/> Progress | |

concerning my: Accident Injury Illness

Other _____

To be released to:

(Name of Practitioner, Doctor, family member etc.)

Address: _____

Fax: _____

For the purpose of:

(Specify)

Signed: _____ Date: _____

- | | | | |
|----------------------------------|---------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent | <input type="checkbox"/> Guardian |
|----------------------------------|---------------------------------|---------------------------------|-----------------------------------|